The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see https://kp.org/plandocuments or call 1-800-290-8900 (TTY: 711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-290-8900 (TTY: 711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or $600 Individual / $1,200 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$7,000 Individual / $14,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover, indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-800-290-8900 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Plan Provider (You will pay more)	Non-IHCP Non-Plan Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	$15 / visit; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with referral.
	Specialist visit	No Charge	$40 / visit; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with referral.
	Preventive care/ screening/ immunization	No Charge	No charge; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	X-ray: $30 / visit; deductible does not apply for x-ray & diagnostic imaging. Lab: $20 / visit; deductible does not apply for laboratory & professional services.	Not covered	Cost sharing waived at non-IHCP with referral.
	Imaging (CT/PET scans, MRI's)	No Charge	$300 / visit	Not covered	Cost sharing waived at non-IHCP with referral. Preauthorization required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Plan Provider (You will pay more)	Non-IHCP Non-Plan Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at kp.org/wa/7formulary2025	Preferred generic drugs	No Charge	Retail: $10 / 30 days; deductible does not apply; Mail Order: $5 / 30 days; deductible does not apply	Not covered	Cost sharing waived at non-IHCP referral. Up to 90-day supply (retail & mail order). No charge for contraceptives, deductible does not apply. Subject to formulary guidelines.
	Preferred brand drugs	No Charge	Retail: $60 / 30 days; deductible does not apply; Mail Order: $55 / 30 days; deductible does not apply	Not covered	Cost sharing waived at non-IHCP referral. Up to 90-day supply (retail & mail order). Subject to formulary guidelines.
	Non-Preferred generic/brand drugs	No Charge	Retail: $100 / 30 days; deductible does not apply; Mail Order: $95 / 30 days; deductible does not apply	Not covered	Cost sharing waived at non-IHCP referral. Up to 90-day supply (retail & mail order). Subject to formulary guidelines.
	Specialty drugs	No Charge	$100 / prescription; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with referral. Up to 30-day supply (retail).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	$350 / visit	Not covered	Cost sharing waived at non-IHCP with referral.
	Physician/surgeon fees	No Charge	$75 / visit	Not covered	Cost sharing waived at non-IHCP with referral.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Plan Provider (You will pay more)	Non-IHCP Non-Plan Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No Charge	$450 / visit	$450 / visit	Cost sharing waived at non-IHCP with referral. Must notify Kaiser Permanente within 24 hours if admitted to a Non-Plan provider; limited to initial emergency only.
	Emergency medical transportation	No Charge	$375 / trip; deductible does not apply	$375 / trip; deductible does not apply	Cost sharing waived at non-IHCP with referral.
	Urgent care	No Charge	$35 / visit; deductible does not apply	$450 / visit	Cost sharing waived at non-IHCP with referral. Non-Plan providers are not covered inside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	$525 / day, up to $2,625; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with referral. Preauthorization required.
	Physician/surgeon fee	No Charge	Included in facility fee	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	$15 / visit; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with referral.
	Inpatient services	No Charge	$525 / day, up to $2,625; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with referral. Preauthorization required.
If you are pregnant	Office visits	No Charge	No charge; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with referral. Depending on the type of service, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery professional services	No Charge	Included in facility fee	Not covered	Cost sharing waived at non-IHCP with referral.
	Childbirth/delivery facility services	No Charge	$525 / day, up to $2,625; deductible does not apply	Not covered	Cost sharing waived at non-IHCP with referral. Newborn services cost shares are separate from that of the mother.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Plan Provider (You will pay more)	Non-IHCP Non-Plan Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	$15 / day; deductible does not apply	Not covered	130 visit limit / year. Cost sharing waived at non-IHCP with referral. Preauthorization required.
	Rehabilitation services	No Charge	Inpatient: $525 / day, up to $2,625; deductible does not apply; Outpatient: $25 / visit; deductible does not apply	Not covered	Inpatient: 30 day limit / year. Preauthorization required. Outpatient: 25 visit limit / year. Cost sharing waived at non-IHCP with referral.
	Habilitation services	No Charge	Inpatient: $525 / day, up to $2,625, deductible does not apply; Outpatient: $25 / visit; deductible does not apply	Not covered	Inpatient: 30 day limit / year. Preauthorization required. Outpatient: 25 visit limit / year. Cost sharing waived at non-IHCP with referral.
	Skilled nursing care	No Charge	$350 / day	Not covered	60 day limit / year. Cost sharing waived at non-IHCP with referral. Preauthorization required.
	Durable medical equipment	No Charge	20% coinsurance	Not covered	Cost sharing waived at non-IHCP with referral. Preauthorization required.
	Hospice service	No Charge	No charge; deductible does not apply	Not covered	Preauthorization required. Inpatient or outpatient respite care limited to a maximum of 14 days / lifetime.
If your child needs dental or eye care	Children's eye exam	No Charge	No charge; deductible does not apply	Not covered	Limited to one exam / year
	Children's glasses	No Charge	No charge; deductible does not apply	Not covered	Limited to one pair of frames and lenses or contact lenses / year.
	Children's dental check-up	No Charge	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Bariatric Surgery • Cosmetic Surgery • Dental Care (Adult & Child) • Hearing Aids	• Infertility Treatment • Long-Term Care • Non-Emergency Care when Traveling Outside the U.S.	• Private-Duty Nursing • Routine Foot Care • Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion • Acupuncture (12 visits / year)	• Chiropractic Care (10 visits / year)	• Routine Eye Care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agency in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-800-290-8900 (TTY: 711) or https://wa.kaiserpermanente.org/html/public/member-services
Office of the Insurance Commissioner	1-800-562-6900 or www.insurance.wa.gov

Does this plan provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Not Applicable.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-290-8900 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-290-8900 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-290-8900 (TTY: 711)

PENNSYLVANIA DUTCH (Deitsch): Fer Hilf griege in Deitsch, ruf 1-800-290-8900 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-290-8900 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-290-8900 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-290-8900 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-800-290-8900 (TTY: 711)

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$525**
- **Other (blood work) copayment** **$20**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$525**
- **Other (blood work) copayment** **$20**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$0**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$40**
- **Hospital (facility) copayment** **$525**
- **Other (x-ray) copayment** **$30**

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

*Note:These numbers assume that patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Notice of Nondiscrimination

Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. ("Kaiser Permanente") comply with applicable Federal and Washington state civil rights laws and do not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity, or any other basis protected by applicable federal, state, or local law. We also:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
    - Assistive devices (magnifiers, Pocket Talkers, and other aids)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Services at **1-888-901-4636** (TTY **711**).

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with our Civil Rights Coordinator by writing to P.O. Box 35191, Mail Stop: RCR-A3S-03, Seattle, WA 98124-5191 or calling Member Services at the number listed above. You can file a grievance by mail, phone, or online at **kp.org/wa/feedback**. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with:

- The U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697** (TDD)
  Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**
- The Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at **https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status**, or by phone at **800-562-6900, 360-586-0241** (TDD). Complaint forms are available at **https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx**

Multi-language Interpreter Services

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-888-901-4636** (TTY **711**).

Español (Spanish): ATENCIÓN: Si habla español, tiene disponibles servicios de ayuda con el idioma sin cargo. Llame al **1-888-901-4636** (TTY **711**).

中文(Chinese)：注意：如果您使用繁體中文，您可 以免費獲得語言援助服務。請致電 **1-888-901-4636** (TTY **711**)。

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị nói tiếng Việt, quý vị có thể sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí của chúng tôi. Xin gọi số **1-888-901-4636** (TTY **711**).

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 제공해 드립니다. **1-888-901-4636** (TTY **711**) 번으로 문의하십시오.

Русский (Russian): ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Звоните по номеру **1-888-901-4636** (TTY **711**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-888-901-4636** (TTY **711**).

Українська (Ukrainian): УВАГА! Якщо ви розмовляєте українською мовою, вам доступні безкоштовні послуги перекладу. Телефонуйте за номером **1-888-901-4636** (TTY **711**).

ភាសាខ្មែរ (Khmer)៖ សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាកម្មជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃគឺ មានសម្រាប់អ្នក។ ទូរសព្ទទៅលេខ **1-888-901-4636** (TTY **711**) ។

日本語 (Japanese): 注意事項：無料の日本語での言語サポートをご利用いただけます。**1-888-901-4636** (TTY **711**) まで、 お電話にてご連絡ください。

አማርኛ (Amharic) ፥ ማስታወሻ:የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እገዛ አገልግሎቶች፣ በነጻ ለእርስዎ ይቀርባሉ፡ ወደ **1-888-901-4636** (TTY **711**)ይደውሉ።

Oromiffa (Oromo): XIYYEEFFANNAA: Afaan dubbattu Oroomiffa yoo ta’e, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. **1-888-901-4636** (TTY **711**) irraatti bilbilaa.

ਪੰਜਾਬੀ (Punjabi)ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ।
1-888-901-4636 (TTY **711**) ‘ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic): انتباه إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية، متوفرة لك، مجانا اتصل بالرق **1-888-901-4636** م (TTY **711**)

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-888-901-4636** (TTY **711**).

ພາສາລາວ (Lao):ໂປດຊາບ; ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ແມ່ນ ຈະມີການບໍລິການຊວຍເຫຼືອດານພາສາໂດຍບໍເສຍຄາໃຫແກທານ. ໂທ **1-888-901-4636** (TTY **711**).